DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 12/03/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING 01 - BUILDING 1 IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION 495410 11/24/2015 STREET ADDRESS, CHY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1739 KIRBY ROAD ARLEIGH BURKE PAVILION MC LEAN, VA 22101 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPHOPRIATE TAG TAG OR LSC IDENTIFYING INFORMATION) DEFICIENCY) K 000 K 000 INITIAL COMMENTS The procedure for auditing the facility's environment has been Surveyor: 29282 Description of structure: The facility is a two story evaluated. Environmental rounding with a construction type of II(111). will also include a review Sprinkler status: The facility is a fully sprinklered building. of facility exit doors and corridors to ensure accessibility. All personnel An unannounced recertification Life Safety Code survey was conducted 11/24/2015 in accordance responsible for monitoring the with 42 Code of Federal Regulation, Part 483.70: environment as it relates to exit doors Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the and corridors have been re-inserviced. 2000 Life Safety Code. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. Weekly monitoring of the environment will continue by the The findings that follow demonstrate Maintenance Supervisor. Any non-compliance with Title 42 Code of infractions noted will be reported to Regulations, 483.70(a) et seg (Life Safety from Fire.) the QA committee for further K 025 NFPA 101 LIFE SAFETY CODE STANDARD K 025 monitoring and evaluation. SS=D Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 01 - BUILDING 1 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 495410 B. WING 11/24/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1739 KIRBY ROAD ARLEIGH BURKE PAVILION MC LEAN, VA 22101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 025 Continued From page 1 K 025 This Standard is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain resistance rating of an assembly. This has the possibility to affect 25% of the residents. The Findings Include: On 11/24/2015 at approximately 10:39 am, it was identified by observation there was an unsealed penetration above the fire doors to the Admin hall. K 072 NFPA 101 LIFE SAFETY CODE STANDARD K 072 SS=D Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Surveyor: 29282 Based on observations it was determined the health care facility failed to maintain an exit. This has the possibility to affect 10% of the residents. The Findings Include: On 11/24/2015 at approximately 10:39 am, it was revealed by observation there were mobile wardrobes partially blocking the exit corridor in Admin.(Corrected on site)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING 02 - COMMUNITY BLDG		(X3) DATE SURVEY COMPLETED	
	495410			B. WING	manifest indicates the second desirable representation above above the property and advantage and ad	11/24/2015	
ARLEIGH BURKE PAVILION 1739 KI				DRESS, CITY, STATE, ZIP CODE IRBY ROAD AN, VA 22101			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL HEC			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
K 000	INITIAL COMMEN	ITS		K 000	K025	01/08/16	
	Surveyor: 29282 Description of structure: The facility occupies two floors of a three story with a basement building with a construction type of I (322). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted on 11/24/2015 in accordance with 42 Code of Federal Regulation, Part 483.70: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2000 Life Safety Code. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.) NFPA 101 LIFE SAFETY CODE STANDARD		ety Code egulation, rm Care Code. the e and	K 025	The flange for smoke damped 136 was corrected on site. It flange for the damper in the electrical room was corrected pipe penetrations on G15 was. A and penetration above the to the Admin hall were scaled. A facility wide audit of all standard fire dampers was performed additional infractions noted wide audit to ensure smoke barriers and/or fire proofing place has been completed be outside contractor.	The fire ad. The all by stair fire doors ed. smoke and d with no . A facility g are in	
SS=f	Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems 18.3.7.3, 18.3.7.5, 18.1.6.3				Scheduled monitoring and/maintenance to the fire dan be completed as recommen manufacturer. Inspection of fing will be added to the "Ental Tools" checklist." The responsible for monitoring environment as it relates to ing and fire dampers have be serviced.	npers will ided by the of fireproo- environme- e personnel of the fireproof-	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY STATEMENT OF DEFICIENCIES A. BUILDING 02 - COMMUNITY BLDG COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 495410 11/24/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1739 KIRBY ROAD ARLEIGH BURKE PAVILION MC LEAN, VA 22101 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 025 K 025 Continued From page 1 Any infractions noted through the scheduled monitoring will be reported to the QA committee. This Standard is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to 01/08/16 maintain the resistance rating of assembly's. K027 This has the possibility to affect 50% of the The fire door to stair B on the first residents. floor has been repaired. The Findings Include: On 11/24/2015 at approximately 09:22 am, it was A facility wide audit of all door

identified by observation the flange for the smoke damper by room 136 was not flush against the wall.(Corrected on site)

On 11/24/2015 at approximately 09:33 am, it was identified by observation the fire damper flange in the electrical room is not installed properly.

On 11/24/2015 at approximately 10:00 am, it was identified by observation there improperly sealed pipe penetrations G15 wall by stair A.

K 027: NFPA 101 LIFE SAFETY CODE STANDARD SS=D

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 13/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8

K 027

openings has been completed with

no additional infractions noted.

The procedure for monitoring the

facility's environment related to door openings has been reviewed and amended. The Quality Assurance tool "Environmental Rounds" has been amended to include the inspection of all door openings to ensure smoke barriers are maintained. The personnel responsible for monitoring of the environment as it related to door openings have been in-serviced.

Weekly monitoring of the facility environment will continue by the Maintenance Supervisor. Any additional infractions noted will be reported to the QA committee for further evaluation.

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The Findings Include:

On 11/24/2015 at approximately 10:04 am, it was

for further evaluation.

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - COMMUNITY BLDG

(X3) DATE SURVEY COMPLETED

495410

B. WING

11/24/2015

NAME OF PROVIDER OR SUPPLIER ARLEIGH BURKE PAVILION

STREET ADDRESS, CITY, STATE, ZIP CODE

1739 KIRBY ROAD MC LEAN, VA 22101

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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT TAG OR LSC IDENTIFYING INFORMATION)	ID ORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
revealed by observation there was paint on several sprinkler heads in the hard ceiling by G06. On 11/24/2015 at approximately 10:06 am, it was revealed by observation there was paint on several sprinkler heads in the elevator 2 lobby. On 11/24/2015 at approximately 10:07 am, it was revealed by observation there was paint on several sprinkler heads in the connector. K 147 NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to prevelectrical hazards. This has the possibility to affect 45% of the residents. The Findings Include: On 11/24/2015 at approximately 9:17 am, it was identified by observation there was an unsupported power strip in the nurse office. (Corrected on site) On 11/24/2015 at approximately 9:30 am, it was identified by observation there was inadequated clearance around a panel box in the electrical room. (Corrected on site) On 11/24/2015 at approximately 9:35 am, it was identified by observation there was an unsupported power strip in the reading lounge (Corrected on site)	ent K 147	The unsupported power strip in the nurse office and reading lounge were both corrected on site. The items prohibiting adequate clearance around the panel box in the electrical room was corrected on site and the open electrical box in the elevator room was closed on site. A facility aide audit of all electrical wiring and equipment to include extension cords, adaptors, all electrical and elevator rooms has been completed with no further infractions noted. The procedure for auditing facility electrical wiring and equipment has been evaluated and amended. Communication has been provided to personnel related to extension cords, power strips and adaptors. Approval by the maintenance department of all extension cords and equipment must be received prior to installation.

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(X2) MULTIPLE CONSTRUCTION
A, BUILDING 02 - COMMUNITY BLDG

(X3) DATE SURVEY COMPLETED

495410

B. WING ____

11/24/2015

NAME OF PROVIDER OR SUPPLIER ARLEIGH BURKE PAVILION

STREET ADDRESS, CITY, STATE, ZIP CODE

1739 KIRBY ROAD MC LEAN, VA 22101

MC LEAN, VA 22101							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K 147	Continued From page 4 On 11/24/2015 at approximately 9:53 am, it was identified by observation there was an open electrical box in the elevator room.	K 147	All personnel responsible for monitoring the environment as it relates to electrical wiring and equipment have been in-serviced. Weekly monitoring of the environment will continue by the Maintenance Supervisor. Any infractions noted will be reported to the QA committee for further monitoring and evaluation. K072 The mobile wardrobes partially blocking the exit corridor in the Admin suite were removed on site. A facility wide audit of all exit doors and corridors has been completed to ensure they are readily accessible at all times with no further infractions noted.	01/08/1			
			Will Lot				